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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G164	A. BUILDING _____ B. WING _____	08/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NCC	617 DAHLIA STREET, NW WASHINGTON, DC 20012

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W 000	INITIAL COMMENTS This recertification survey was conducted from August 15, 2007 through August 17, 2007. The survey was initiated as a fundamental survey, however due to deficient practices the survey process was extended in the Conditions of Client Protection, Active Treatment and Health Care Services. A random sampling of three clients was selected from the residential population of six females with varying degrees of disabilities. The findings of the survey were derived from observation, interview, and the review of client and administrative records, including the review of unusual incidents. The survey findings determined the facility did not meet the requirements under the Conditions of Client Protection and Health Care Services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's governing body provided general operating direction over the facility as evidence by the following and deficiencies cited throughout this report. 1. The governing body failed to have an effective system to ensure that day program receive physician's orders. Interview with the case manager and the review of nursing correspondence at the day program	W 104	W104 A protocol has been developed to ensure the day program receives the physicians orders. All staff have been trained on the protocol. (attachment #1)	9/21/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Program Manager 9/24/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 revealed repeated requests for current physician's orders (9/19/06, 9/27/06, 11/6/06, 1/10/07, 5/22/07, 6/22/07). Interview with the supervisory RN on 8/17/07 at approximately 4:30 PM revealed the orders were sent by the bus driver to the day program and that she had not been notified by the day program that the medication orders were not received. 2. The governing body failed to have an effective system to ensure that medicaid approval for dental services are received timely. [See W356]	W 104		
W 114	2. 483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all personnel making entries into client records dated and signed each entry, for three of three clients in the sample. (Clients #1, #2 and #3) : The findings include 1. [Cross Reference W331] Review of the nursing records revealed a progress note dated 2/28/07. The note revealed that Client #3 was assessed and determined to have right thigh swelling, inability to ambulate, and pain on range of motion. The note was not initial/signed and did not reflect the time of the assessment. 2. Review of Clients #1, #2, and #3 monthly	W 114	W114 1. Program Nurse will be trained on appropriate documentation to include signing off on nursing notes. 2. The QMRP will be trained in the appropriate documentation of progress notes to include signing off.	10/1/07 10/1/07

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W 114	Continued From page 2 progress monitoring notes for October, November, and December 2006 failed to have the signature of the person who completed them. Interview with the program manager revealed that the monitoring notes should have been completed and signed by the QMRP.	W 114		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that outside services met the needs of one of three clients in the sample (Clients #3). The findings include: The facility failed to ensure the dental services consultant provided services timely and in accordance with recommended treatments. a) A dental consultation report for Client #3 dated September 13, 2006 revealed a finding of heavy calculus and a recommendation for scaling of teeth. The recommended services were not performed on that day. The consultant's report revealed that the dentist would submit preauthorization to Medicaid for approval, and would call to reschedule once the approval was received. Interview with the group home nurse on August 16, 2007 at 11:08 AM revealed the scaling had not been performed. b) On June 11, 2007 the client returned to the dentist and was diagnosed with a mobile tooth	W 120	W120 An appointment will be scheduled for client #3 to receive scaling and all additional dental work needed.	10/31/07

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W 120	Continued From page 3 #11 and gross decay of tooth #3. There were no dental services to correct the identified problem during that visit. The consultant's report revealed that the dentist would submit preauthorization to Medicaid for approval, and would call to reschedule once the approval was received. At the time of the survey the dental services had not been completed. There was no evidence an effective system was established by the dental provider for timely monitoring of the status of outstanding requests for preauthorizations needed to provide dental treatment services. [See also W356, 1]	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to implement its Incident Reporting policies and procedures (See W149); failed to provide evidence that all allegations of neglect were thoroughly investigated (See W154); and to failed to document the notification of the administrator of investigation findings within 5 working days of the incident (See W156). The effect of this systemic practice results in the failure of the facility to protect its clients' rights and to ensure their general safety and well being.	W 122		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients	W 137	W137 All Staff and QMRP will be trained on appropriate clothing for consumers and providing day program with a change of clothing regularly.	10/24/07

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W 137	Continued From page 4 have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each clients clothing were of the appropriate size, for three of the six clients (Clients #1, #3, and # 5) residing in the facility. The finding includes: 1. On 8/15/07 at 8:15 AM Client #3 was observed wearing a shirt which was too large as she left the group home for her day program. At 12:20 PM and 5:43 PM the client was observed wearing the same shirt. The neckline of the shirt was large, would not stay in place when repositioned, and intermittently slid to the client's upper arm, partially exposing her bra. 2. On August 15, 2007 at 5:23 PM, Client #1 was observed leaving the facility with staff for a community walk. Further observation revealed the client wearing a green flowered shirt which was too large and a pair of medium blue very wrinkled shorts. 3 Interview with the Activities Coordinator at Client #1's day program on August 15, 2007 at 10:30 AM revealed she returned to the day program without a change of clothing that morning, after being out for several days. Interview with the client's day program instructor on 8/15/07 at 10: 39 AM revealed the client was incontinent and was on a Q 2 hour toileting schedule. On the next day, August 16, 2007, the group	W 137		

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W 137	Continued From page 5 home received a telephone call from Client #1's day program (located nearby) indicating that she had soiled her clothing and did not have a change of clothing. The day program was informed that no one was available to bring more clothing for the client. A change of clothing was provided to the client by the day program. Interview with the program manager on August 16, 2007 at 11: 35 AM indicated that a change of clothing was left at the day programs for the clients to ensure that they have them when they need them.	W 137		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a system that ensured a full and complete accounting of clients' personal funds entrusted to the facility for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: Interview with the program manager on August 16, 2007 at 11:43 AM revealed the group home manager maintained the receipts of the clients' expenditures and submitted them to the administrative office for review and filing in the clients financial records. Further interview with the program manager revealed the group home manager had not been on duty since August 14, 2007.	W 140	W140 The house manager responsible for the missing receipts left NCC unexpectedly and NCC was unable to recover the receipts. QMRP and staff will be trained on appropriate receipt submission. W149	

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W 140	Continued From page 6 Record review on August 16, 2007 beginning at 11:52 AM revealed the following information concerning the finances of the clients: a) The review of the bank statements for May 2007 revealed on May 14, 2007 Clients #1, #2, and #3, each had a withdrawal of $250.00 from their accounts. The review of the requests for the funds indicated the money was to be used for clothing and personal items. The review of available financial records revealed no receipts were available for the $250.00 withdrawals. Interview with the program manager on August 16, 2007 at 12:36 PM indicated that follow-up was needed to determine if the receipts had been submitted to the financial office. b) The review of Client #1's bank statements from September 2006 through July 2007 revealed the bank statements reflected a balance of $100.00 less than the facility's ledger balances. Further review of the facility's monthly ledgers revealed the discrepancy was initially discovered by the facility in September 2006. A note on the December 2006 bank statement indicated "There is a $100.00 difference in the bank and book ledger. We are still waiting to follow-up with the bank on this issue." At the time of the survey, there was no evidence a thorough investigation had been conducted to determine the origin of the discrepancy between the client's bank and ledger balances. c) Interview with the program manager on August 16, 2007 at 11:55 AM revealed the clients went on a summer vacation in another state during July 2007. The review of the July 2007 bank statements revealed withdrawal of $530.00 on	W 140		

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W 140	Continued From page 7 July 23, 2007 for Clients #1, #2, and #3. Interview with the program manager revealed the home manager maintained the receipts and they were not available for review during the survey.	W 140		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement their incident management policies to ensure the health and safety of one of the three clients (Client #3) included in the sample. The findings include: 1. The facility failed to have an incident management policy that clearly outlined notification timeframe as evidenced below: Review of the facility's investigative report on August 17, 2007 revealed on February 28, 2007 Client #3 was discovered on her bedroom floor between 5:30 AM and 5:40 AM unable to stand. [Note: According to the investigative report, the client's sleeping on the floor was not unusual.] Interview with the direct care staff revealed that the QMRP and the house manager (supervisors) were contacted via telephone immediately after the client was discovered unable to stand. There was no evidence, however, that the direct care staff or their supervisor contacted nursing/medical personnel at that time.	W 149	W149 Educate nursing staff on writing progress notes – specifically, distinguishing how to indicate time of events in the notes vs. the time of the note, which will aid in clarifying the sequence of events. (meeting scheduled for 9/27/07) Revised the "Emergency Medical Treatment – No Nurse on Site" policy	9/27/07

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W 149	Continued From page 8 According to the facility's investigative report dated March 14, 2007, when the medication nurse arrived to the facility to administer clients' medication, she was informed at that time of Client #3's condition. Interview with the nursing staff (Primary RN and Supervisory RN) and review of the incident report dated 2/28/07 revealed that the client was assessed to be in pain at 8:00 AM. Review of the Medication Administration Records revealed that Client #3 received Tylenol 650 mg by mouth for pain on February 28, 2007 at 7 AM from the medication nurse, prior to the nursing assessment. According to the report, the medication nurse (LPN) assessed the client at 8:00 AM (2 1/2 hours after the incident). At approximately 9:00 AM (1 hour after the nurse's assessment) the facility's Registered Nurse (RN) was telephoned by the medication nurse and informed of the client's inability to stand, her slightly swollen legs, and that the client appeared to be in pain. Two registered nurses (Supervisor and Primary Care Nurse) arrived separately to the facility between 9:30 AM and 10:00 AM. It should be noted that the medication nurse (LPN) left the facility prior to the RNs' arrival. The investigative report reflected that the RN (Supervisor) did not assess the client until 11:00 AM (5 1/2 hours later), and at that time noted "right thigh swelling, inability to ambulate, pain on ROM, no swelling to lower extremity noted." Also at that time, the Primary Care Physician (PCP) was contacted and instructed the nurse to send client to the emergency room. Review of the facility's policy on August 16, 2007 at 2:45 PM required that all injuries alleged or suspected of being the result of any form of	W 149		

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W 149	Continued From page 9 abuse or neglect receive examination of the individual by the physician, nurse practitioner, or other medical professional qualified to make a medical assessment of the injury immediately or within one hour. Further review of the facility's policy revealed, "If emergency medical evaluation is necessary, but not 911 - ambulance service" the facility was required to: 1) Administer emergency medical care as indicated; and 2) Notify the staff physician and proceed as ordered. This policy, however failed to clarify personnel and the time frame for which these steps should be implemented. 2. [Cross Reference W192] There was no evidence that the facility had implemented its policy to ensure that all staff were trained on emergency protocols and first aid.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all allegations of neglect were thoroughly investigated, for one of the three clients (Client #3) included in the sample. The finding includes: On August 17, 2007 the facility incident management system was reviewed. As part of that review, an internal investigation of Client #3's	W 154		

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W 154	Continued From page 10 fracture hip was reviewed. Although the investigation revealed an evidence list to include witness statements, there were no witness statements available for review. On August 17, 2007 the nursing and direct care staff, who were witnesses reflected in the investigation, were interviewed. The interviews revealed discrepancies and information that was not included or clarified in the investigative report. For example: a) According to the direct care staff, the client often got out of her bed during the night to sleep on the floor. Although the client had a diagnosis of osteoporosis, the investigation did not examine or questioned the staff as to how the client transfers from the bed to the floor. It should be noted, that a 2006 occupational therapy assessment recommended that the client be assisted with bed transfers. Also it should be noted that the facility's human right committee reviewed the investigative report and questioned the facility's need for a special protocol for clients who were medically fragile (i.e. clients who have been diagnosed with osteoporosis and unable to express themselves.) b) Interview with the nurses revealed that pain medication was administered on 2/28/07 to address the client ROM pain. The investigation did not revealed that pain medication (Tylenol) was given. The medication administration records however, reflected that medication was given at 7:00 AM by the LPN. Review of the investigative report revealed the client was assessed by the LPN at 8:00 AM. c) Interview with the nurses revealed that the RN arrived at the facility at approximately 9:30 AM.	W 154	W154 This incident was not alleged or suspected to be abuse. The investigator will ensure that future investigation file folders will contain complete witness statements. (a) In the future, the investigator will ensure that a thorough review of client medical records will be completed as part of the investigation. The PT/OT will reassess client #3 to determine if a transfer protocol is needed. If needed training for all staff will be completed. (b) The investigator will add an addendum to the record indicating that Tylenol was administered to the client by the LPN. (c) Although the investigator did not discuss the issue of a delay (there are no NCC policies that specify a time line for this), the Incident review Committee did discuss the delay in their review of the investigation report. The investigator will ensure that this type of information will be included in future reports.	9/24/07 9/24/07 10/15/07 9/24/07 9/24/07

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W 154	Continued From page 11 The investigation revealed that the client was not assessed until 11:00 AM. The investigation did not discuss the 1 1/2 hour delay in the nurses' assessment. c) Interview with the direct care staff, who were on duty at the time the incident revealed that they telephoned the QMRP and the house manager immediately (5:40 AM) upon discovering the client's condition. The investigation did not include what client care instructions, if any, were provided to staff at that time. d) Review of the investigative report reflected at 8:00 AM the direct care staff discovered the client asleep on the floor and unable to stand by herself. Interview with the direct care staff revealed that the client was discovered between 5:30 AM and 5:40 AM. Also the investigation reflected that the medical and supervisory staff were immediately notified and the client was taken to the hospital. Interviews however revealed the nursing staff was notified 2 1/2 hours after the incident and the physician was contacted 5 hours after the incident. Also it should be noted that the facility's human right committee reviewed the investigative report and questioned " did the nurse wait too long before calling the physician?	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.	W 156	W156 The incident in question was classified as Hospitalization rather than Injury of Unknown Origin. In the future, the investigator will apply the classification with the greater standard (five day rule) to incidents and investigate accordingly.	10/1/07

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W 156	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify the administrator of the result of investigations with in 5 days as required, for one of the three clients (Client #3) in the sample. The finding includes: On August 17, 2007 review of the facility's system for investigations revealed an investigaton of an injury of unknow origin discovered on February 28, 2007 at 12:00 AM. The investigation was initiated on Februry 28, 2007, however, it was no completed until March 14, 2007. There was no evidence that the facility's administrator was notified of the results of the investigation within 5 working days. [See W149]	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP) for three of three clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. The QMRP failed to ensure as soon as the	W 159	W159 (1) The QMRP will be trained in the timely notification of ISP/IPP implementation.	10/1/07

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W 159	Continued From page 13 interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for Clients #1, #2 and #3. [See W249] 2. Interview with the Activities Coordinator at Client #1's day program on August 15, 2007 at 10:34 PM revealed she was being sent home from the day program due to no medical clearance to return to the day program after treatment for an eye infection. At 10:39 AM Client #1 was observed sitting in her class room and to have a slightly darkened area around her left eye. At 2:00 PM the client was observed back at the group home. Interview with group home staff on 8/15/07 2:25 PM indicated the the client seemed ok and that they were not aware she was not cleared to return to the day program on the morning of 8/15/07. Interview with the supervisory RN on 8/15/ 07 at 7:10 PM revealed the client had completed her antibiotic therapy and that the PCP said she could resume her day program after she finished the 7 days of antibiotic on 8/14/07. She stated that she was not informed that the client was sent home from the day program. On 8/15/07 at 7:10 PM, the RN contacted the PCP and obtained the medical clearance for the client to return to the Day Program on 8/16/07. There was no evidence information was coordinated to ensure all necessary persons were informed of the need for the medical clearance before the client was allowed to return to her day program. 3. The QMRP failed to coordinate Client #3 goal designed to improve her self feeding skills with the with the nutritionist.	W 159	(2) A protocol will be developed to ensure information regarding consumers returning to the day program are communicated by the QMRP and/or house manager to the direct-care staff. (3) Cross-reference W159 (#1). Program nursing will be trained in verbally communicating pre and post hospitalization weights to the Nutritionist.	10/1/07 10/1/07

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W 159	Continued From page 14 Client #3 was observed being provided standby assistance and encouragement by staff to pick up her spoon and eat during lunch and also at her group home during dinner on August 15, 2007. Although the client fed herself, she was observed to require frequent verbal prompts to continue eating. The review of Client #3's ISP dated 5/21/07 revealed the IDT approved a goal to improve Client #3's skill of feeding herself with spoon. The client had a program objective that "During meal time, when table is set [Client] will pickup spoon and feed self with 80% independence". According to the ISP, the client's progress in this objective was to be monitored by the QMRP. The review of the program data and interview with the QMRP on August 17, 2007 at 2:47 PM revealed that data was not collected until August 13, 2007. The review of the annual nutritional assessment dated dated May 21, 2007 revealed no evidence the client's self feeding deficit and training need had been conveyed to the nutritionist. Additionally, there was no evidence the QMRP had conferred with the nutritionist concerning the client's weight loss during her hospitalization. [See W460] 4. The QMRP failed to coordinate with Developmental Disability Services (DDS) and the day program regarding Client #3 lack of and current ISP at the day program. On August 15, 2007 at 10:39 AM Client #1 was observed with her classroom instructor. Interview with the classroom instructor revealed that both she and the client had transferred to the day	W 159	(4) The QMRP will be trained to review the ISP during monthly visits to the day program to ensure they are current.	10/1/07

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W 159	Continued From page 15 program approximately 15 months earlier when the previous day program closed. Interview with the client's day program instructor and the review of program objectives revealed sensory, and recreation and leisure objectives were being implemented. Interview with Client #1's day program case manager and the record verification at the day program on August 15, 2007 at 10:39 AM revealed no current ISP was available for the client. Further interview with the case manager and the record review revealed the date of the client's last available ISP was May 26, 2005. Interview with the case manager also indicated that having access to the ISP facilitates more effective coordination of the client's service needs at the group home and at the day program. 5. The QMRP failed to ensure the individual program plan stated the specific objectives recommended to address Client #1's communication needs. [See W227] 6. On August 15, 2007 at 8:15 AM, Client #5 was observed to be very slim as she assisted in clearing the table after breakfast. On August 15, 2007 at 4:58 PM the program manager provided information which revealed Client #5 was prescribed a Puree, Double Portion Diet with Ensure Plus, 1 can daily. On August 16 2007 at 7:52 AM the client was observed in the living room with an 8 ounce can of Ensure. Interview with staff on August 17, 2007 at 4:40 PM revealed the client received Ensure twice a day to promote weight gain. Subsequent observation of the supply of the supplement in the store room revealed only Ensure was available. The Ensure Plus was not provided.	W 159	(5) Cross-reference W227 (6) NCC will obtain the proper supplement for client #5 and train staff in the administration of the supplement.	

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W 159	Continued From page 16 7. Client #3's Occupational Therapist recommended on April 24, 2006 that the client be provide assistance during bed transfers to ensure her safety. There was no evidence that the QMRP address the OT recommendation. It should be noted that interviews with direct care staff on August 17, 2007 revealed that the client likes to sleep on the floor. According to staff, the client independently gets out of bed during the night to sleep on the floor. Also, according to staff, they allow her to sleep on the floor. Review of records did not reveal a protocol for sleeping on the floor. It also should be noted, that the review of an investigation report revealed after the the client was observed sleeping on the floor, she was discovered unable to stand as she was later diagnosed with a right fractured hip.	W 159	(7) Cross-reference W154 (a)	10/15/07
W 185	483.430(c)(4) FACILITY STAFFING The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide sufficient support staff so that direct care staff were not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. to provide sufficient direct care staff so that to manage and supervise one of three clients in the sample. (Client #3).	W 185	W185 The vacant house manager's position normally assist with the morning care of clients. Until that position is hired NCC will provide one additional staff from 6am to 9am to assist with consumer care.	10/31/07

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W 185	Continued From page 17 The finding includes: On August 16, 2007 at 7:20 AM two staff (Staff #5 and Staff #6) were on duty to provide direct care services to five (5) clients. Although the facility met the minimal staffing requirement, the staff on duty failed to provide sufficient active treatment and direct care services as evidenced below: At 7:20 AM during breakfast Clients # 1 and #4 were observed with a large, long bib tied around their necks as they ate their meals. The ends of the bib were used as a placement, as they extended from the client's neck to underneath the plates on the table. At 7:22 AM Client #1's plate was observed to slide on the bib as she attempted to scoop food from it using her right hand. Interview with staff indicated the bib is used to prevent the client from soiling their clothing while feeding themselves. At 7:35 AM Client #4 was observed to remove the bib from her neck after finishing her meal. The bib remained on the table underneath the plate and the crumbs fell onto the client's lap. There was no evidence the clients were provided with an appropriate place mat for use during their meals. Review of the client's individual program plan (IPP) did not include an objective to use a napkin. From 8:00 AM to 8:23 AM Staff #6 was observed groomed clients' hair. At 8:09 AM, Client #4, who was coming from the bathroom, was observed in the dining with her pants and underpants halfway down. Interview with the Staff #6 revealed that the client needed assistance with dressing. While standing in the	W 185		

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W 185	Continued From page 18 living room, the staff staff pulled the client's pants up. At 8:15 AM the facility van arrived to transport the client to their day programs. The clients, however, were not ready to depart because of clients' hair had not been completed. The clients departed the facility at 8:25 AM. Although interview with the direct care staff revealed that Clients #5 and #4 were capable of dressing with assistance, the clients were not observed to participate in the hair grooming. At 8:25 AM Staff #5 was observed vacuuming the living room and Client #3, who remained at the facility, set in a dining room chair in the living room. She was not engage in any activity. At 8:57 AM, the client got up from the chair. Undetected by staff, a large circular wet area was observed in the seat of the client's pants. The chair which was upholstered was also wet. At 8:52 AM Staff #5 was observed mopping the dining room floor. The client, who was not directly supervised, walked for 2 minutes on the wet dining room wearing wet pants and no direct supervision. At this time Staff #6 was in the bed room area and Staff #5 was preparing to go off duty. At 9:15 AM Staff #6 called Client #3 to the nurse station to receive his medication. At this time, the staff noticed the client's wet pants. At 9:25 AM, after the client received his medication, Staff #6 changed the client's pants. Note: The seat of the chair was not observed being cleaned during the survey.	W 185		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM	W 192		

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W 192	Continued From page 19 For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures to prevent neglect for six of six clients in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. There was no evidence that the staff on duty had been trained in signs and symptons of injuries and first aid as evidenced below: Review of the facility's investigative report on August 17, 2007 revealed on February 28, 2007 Client #3 was discovered on her bedroom floor between 5:30 AM and 5:40 AM unable to stand. [Note: According to the investigative report, the client's sleeping on the floor was not unusual.] Interview with the direct care staff revealed that the direct care supervisors were contacted via telephone immediately after the client was discovered unable to stand. There was no evidence, however, that the direct care staff or their supervisors contacted nursing/medical personnel at that time. Also, there was no evidence that the direct care staff were given instruction on how to care for the client in lieu of her inability to stand. The direct care staff indicated in their interview on August 17, 2007 at 10:10 AM that they assisted the client to the bathroom for morning hygiene care. Because the client was unable to stand, the staff allowed the client to sit on the edge of the tub while she was	W 192	W192 (1) Staff will be trained on signs and symptoms of injury. All staff will be trained in CPR/First Aid.	9/24/07 10/31/07

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W 192	Continued From page 20 bathed. Approximately 5 hours later the client was later taken to the emergency and diagnosed with a right hip fracture. 2. Review of Client #3's physician orders revealed that the client was diagnosed with osteoporosis and prescribed Cal-carb w-/vit D 600/200 (2 tabs) daily and Actonel 35 mg once weekly its management. On April 24, 2006, Client #3's Occupational Therapist recommended that the client be provide assistance during bed transfers to ensure her safety. There was no evidence that the facility had implement a training program to address the OT's recommendation. a) Interview with direct care staff on August 17, 2007 revealed that Client #3 "likes to sleep on the floor at times". The staff indicated that the client would get out of bed and lie on the floor. The investigative report comfirmed that the client often sleeps on the floor and had done this for many years. The investigation did not examine or questioned the staff as to how the client transfers from the bed to the floor. Also it should be noted that the facility's human right committee reviewed the investigative report and questioned the facility's need for a special protocol for clients who were medically fragile (i.e. clients who have been diagnosed with osteoporosis and unable to express themselves.) b) On February 28, 2007 at 11:00 PM the direct care staff, going off duty, observed Client #3 in her bed. At 12:00 midnight, however, the overnight direct care staff observed the client lying on the floor in her bedroom asleep. They allowed her to remain on the floor and checked	W 192	(2) Cross-reference W159 #7	

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W 192	Continued From page 21 on her hourly. The staff stated that "we did not bother her because she is easily aroused and would get-up and start walking around." Between 5:30 AM and 5:40 AM, the client was awaken by staff, but could not stand. The client was later diagnosed with a right fractured hip. It could not be determined if the client fell from her bed or independently transferred from her bed to the floor. 3. Interview with the program manager on August 16, 2007 at 3:50 PM indicated each staff did not have current CPR certification. The review of training records provided to the surveyor on June 16, 2007 revealed no documented evidence that two of the six direct care employees working with the clients, Staff #2 and Staff #5 had a current CPR certification. 4. Interview with the program manager on August 16, 2007 at 3:50 PM indicated each staff did not have current first aid certification. The review of training records provided to the surveyor on June 16, 2007 revealed no documented evidence that two of the six direct care employees working with the clients, Staff #2 and Staff #5 had a current first aid certification.	W 192	(3 & 4) All staff will be trained in CPR/First Aid.	10/31/07
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's facility failed to ensure comprehensive reassessment to determine the nutritional needs for one of three clients in the	W 212		

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W 212	Continued From page 22 sample. (Client #3) The finding includes: The review of an unusual incident report on August 15, 2007 at approximately 9:30 AM revealed on February 26, 2007 Client #3 was hospitalized for surgical repair of a right hip fracture of unknown origin. The review of the clients Annual Individual Support Plan (ISP) dated May 26, 2007 revealed a diagnosis of osteoporosis. According to the hospital discharge summary dated March 8, 2007, the client was transferred to an extended care facility for rehabilitation and physical therapy. Client #3 was readmitted to her group home on April 23, 2007. On August 15, 2007 at 12:10 PM at her day program and again at PM 6:40 PM at the group home, Client #3 was observed to require continuous prompts by staff to feed herself. The client appeared to become easily distracted and was looking around. The annual nutritional assessment dated May 21, 2007, which was conducted for the ISP, documented that the client weighed 93.5 pounds (healthy weight: 79 - 104 pounds). The review of nursing weight records revealed the client weighed 93 pounds in February 2007 prior to her hospitalization and 85 pounds in May 2007. During the assessment, the nutritionist recommended that the client's intake and weight be monitored for changes. The weight chart maintained by the nurse revealed the following additional weights were documented: a) June 82 pounds; b) July 83 pounds; August 80 pounds Record review revealed the change in the client's	W 212	W212 Cross-reference W159 (#1). Program nursing will be trained in verbally communicating pre and post hospitalization weights to the Nutritionist and Physician.	10/1/07

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W 212	Continued From page 23 weight had not been identified by the nutritionist and that no further nutritional recommendations were made to address the weight loss.	W 212		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the individual program plan stated the specific objectives necessary to meet the client's communication needs for one of three clients in the sample. (Client #1) The finding includes: Interview with the direct care staff on August 17, 2007 as 9:15 AM revealed that Client #1 was able to say a few simple words, "no, get out, go home, eat" and may be able to learn a few other simple words. Direct staff also stated that the client understands "Sit on the toilet". Record review revealed Client #1's annual Speech-Language Pathology (SLP) Assessment was completed for the May 31, 2007 Individual Support Plan (ISP). The assessment included an expected outcome for the client to increase expressive communication through the use of an augmentative alternative communication (AAC) device and included two objectives: a) Objective - [Client] will use an AAC device to make requests for eating, drinking, sleeping, and	W 227	W227 A augmentative alternative communication device has been purchased for client #1 and staff will be trained on its implementation.	10/15/07

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W 227	Continued From page 24 using the bathroom with hand over hand assistance. b) Objective - [Client] will use an AAC device to say hello and good-bye with hand over hand assistance.	W 227		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in privacy and dressing skills for one of six clients residing in the facility. (Clients #4) The finding includes: 8/15/07 at 5:10 PM, and on 8/16/07 at 8:09 AM and at 5:46 PM Client #4 was observed in the hallway with her slacks and panties pulled halfway up on her hips. The client continued to attempt to pull both the pants and panties up at the same time. The client was intercepted by staff as she was walked past the dining table. She was escorted back into the bathroom to pull up her pants and to wash her hands. Interview with staff on 8/17/07 revealed that the client can dress herself, but required assistance and monitoring.	W 242	W242 Program team meeting will be held to determine need for development and implementation of a dressing goal. Furthermore, staff will be trained in providing privacy to consumers while dressing.	10/10/07

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W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. [Cross Reference W252] The facility failed to ensure continuous active treatment for Client #3. Goal - to improve her money management skills. Objective - When given the opportunity to go shopping, [Client] will pay for items purchased from the community store with 60% independence. The client was not observed to go to the store during the survey. Instructions for completing the objective revealed it should be implemented daily and documented on Saturdays. Further record review revealed no evidence this objective had been implemented since the May 26, 2007 ISP.	W 249	W249 QMRP will be trained in ISP implementation and monitoring to ensure documentation of goals/objective are completed in accordance with appropriate timelines.	10/1/07

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W 249	Continued From page 26 2. [Cross Reference W252] The facility failed to consistently implement Client #1 ISP objectives. Record review revealed an ISP dated May 31, 2007. According to the IPP, the client had the following goals and objectives: Goal - to improve money management skills Objective - When given the opportunity to go shopping [Client] will insert money in a vending machine to pay of the purchase of items with 60% independence. No data was available since the ISP. 3. [Cross Reference W252] The facility failed to consistently implement Client #3 ISP objectives. Record review revealed an ISP dated May 31, 2007. According to the IPP, the client goals and objectives included the following: a) Goal - to improve self help skills Objective: When prompted will pick out a set of clothes to wear with 80% independence. Interview with staff on August 17 2007 at 9:17 AM revealed she is also able to dress herself, but requires assistance with fasteners and to have her clothing selections checked by staff. No data was available since the ISP. b) Goal - To improve money management skills Objective - At appropriate [Client] will insert money in vending machine to purchase item with assistance. No data was available since the ISP.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 27 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the program objective was documented in measurable terms for three of three clients in the sample. (Client #3) The findings include: 1. The facility failed to document Client #3's performance of her walking objective. On August 15, 2007 at 8:10 AM Client #3 was observed independently ambulating in the living, dining, and kitchen areas of the facility. Interview with staff on August 15, 2007 at 4:15 PM revealed the client loves to walk. Staff was observed returning from a walk with direct care staff on August 15, 2007 (Wednesday) at 4:21 PM. On August 16, 2007 (Thursday) at 4:02 PM the client was observed returning from another community walk with a direct care staff Record verification on August 17, 2007 at 2:45 PM revealed the client had a goal to improve her walking skills. The record further documented an objective which states " When prompted [Client] will go for walk around her community for 30 minutes". Instructions to staff require daily implementation of the objective and data collection only on Tuesday and Thursdays. The review of program data on August 17, 2007 at 2:49 PM reveal no evidence that either of the two community walks had not been documented on the data collection sheet.	W 252	W252 All staff will be trained on goals/objectives of all consumers in the home. The QMRP will be trained in ISP implementation and monitoring to ensure documentation is correct and completed in a timely manner. QMRP will include a status report on all ISP goals/objective in the monthly program note.	10/30/07

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W 252	Continued From page 28 2. On August 15, 2007 at 12:10 PM and 6:40 PM Client #3 was observed to require continuous prompts from by staff to feed herself. The client appeared to become easily distracted and was looking around. The review of the client's ISP dated May 26, 2007 revealed the following goals and objectives were recommended by the IDT. a) Goal - to improve the skill of feeding self with spoon. Objective - During meal time, when table is set [Client] will pickup spoon and feed self with 80% independence. The review of the IPP revealed the client's progress in this objective was to scheduled to be monitored by the QMRP. The review of the program data and interview with the new QMRP on August 17, 2007 at 2:47 PM revealed no data collection was available since the ISP until August 13, 2007. b) On August 15 and 16, 2007 staff was observed escorting Client #3 to the bathroom to wash her hands prior to her eating the afternoon snack and dinner. Interview with staff on August 17, 2007 at 9:20 AM indicated the client was receiving training to wash her hands. Record verification revealed a May 26, 2007 ISP goal to improve hygiene skills. The objective states "When prompted [Client] will wash her hands with at least 60% independence." Instructions for completing the objective revealed it should be implemented daily and documented two times a week. Record verification indicated the program was implementation on August 13, and 15, 2007. Interview with the new QMRP and record review on August 17, 2007 revealed that no data collection had been maintained on this objective prior to August 2007.	W 252		

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W 252	Continued From page 29 c) Staff was observed returning from a walk with direct care staff on August 15, 2007 (Wednesday) at 4:21 PM. On August 16, 2007 (Thursday) at 4:02 PM the client was observed returning from another community walk with a direct care staff. Interview with direct care staff on August 16, 2007 at 8:45 AM revealed Client #3 "loved to walk." Record verification revealed the following: Goal - to improve the client's walking skills. Objective - "When prompted, [Client] will go for a walk around her community for 30 minutes." Instructions for completing the objective revealed it should be implemented daily and documented on Mondays and Tuesdays. Interview with the new QMRP and record review on August 17, 2007 revealed that no data collection had been maintained on this objective after the 5/26/07 ISP until August 2007. Interview with the program manager on August 17, 2007 indicated the client's walking objective was implemented however, the QMRP failed to developed the data collection sheet for the staff to document the client's performance in the objective. During the survey, it could not be verified that Client #3 received continuous active treatment to address her needs as identified by the IDT. 2. The facility failed to consistently implement Client #1 ISP objectives. Record review revealed an ISP dated May 31, 2007. According to the IPP, the client had the following goals and objectives: a) Goal - To increase self help skills Objective - With hand over hand assistance	W 252		

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W 252	Continued From page 30 [Client] will wear her stockings 60% of the opportunities(data available for 2 days in 8/07 only since the ISP). On August 16, 2007 at 7:50 AM., Client #1 was observed to pull off her socks and lift her foot to have staff put them on again. Interview with staff on August 16, 2007 at 8:10 AM revealed Client #1 does not like to keep on her socks, and likes to walk around and play. After returning home from her day program on August 15, 2007 and August 16, 2007, the client was observed to pull off her sock and to walk barefoot until staff noticed her and put the socks back on her feet. Data only available for 2 days in 8/07 since the ISP. b) Goal - To improve home management skills Objective - After meal [Client] will take the cup/ dishes to the kitchen sink with 50% independence (2 times a week). At 7:00 PM PM on August 15, 2007, the client was observed to take her cup to the kitchen with verbal prompts. Data was on available only for 4 days in 8/07 since the ISP. d) Goal - To improve her walking skills Objective - When prompted [Client] will go for a walk around her community for 30 minutes. Staff was observed returning from a walk with direct care staff on August 15, 2007 at 4:21 PM, however failed to document on the IPP. Interview with the program manager on August 17, 2007 indicated the staff implemented the IPP objectives developed by the IDT. The program manager acknowledged however that the previous QMRP failed to develop IPP data collections forms on which the staff could document the clients performance.	W 252		

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W 252	Continued From page 31 3. Client #2 program's data was reviewed and revealed the following: a) Goal - to improve self help skills Objective: When prompted will pick out a set of clothes to wear with 80% independence. Interview with staff on August 17 2007 at 9:17 AM revealed she is also able to dress herself, but requires assistance with fasteners and to have her clothing selections checked by staff. No data was available since the ISP. b)Goal - To improve walking skills Objective - With verbal prompts and supervision, [Client] will participate in a walking program around her home or in her community for 30 minutes 80% of the opportunities. On August 15, 2007 at 4:05 PM, the client went for a walk in the community with a direct care staff. Data only available for 1 days in 8/07 since the ISP. c) Goal - To improve money management skills Objective - At appropriate [Client] will insert money in vending machine to purchase item with assistance. No data was available since the ISP.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to effectively train staff to implement emergency measures to prevent neglect (See W192); and failed to obtain preventive and adequate nursing care to prevent neglect (See W322 and W331).	W 318	W318 Cross-reference W192, W322, and W331	

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W 318	Continued From page 32 The results of these systemic practices resulted in the demonstrated failure to provide health care services to prevent neglect.	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to obtain preventive care to prevent neglect for one of three clients in the sample (Client #3). The findings include: 1. [Cross Reference W192] The facilty failed to ensure prompt nursing/medical services to address Client #3's injury as evidenced below: Review of the facility's incident and investigative reports on August 17, 2007 revealed on February 28, 2007 Client #3 was discovered on her bedroom floor between 5:30 AM and 5:40 AM unable to stand. [Note: According to the investigative report, the client's sleeping on the floor was not unusual.] Interview with direct care staff revealed that they called their supervisors (non-medical personnel) to report the client's condition. It is unclear as to what instructions were given to the direct care staff on how to proceed with the client's care. According to the investigative report, a direct care staff made two attempts to help the client stand, but each time, the client appeared to be weak in	W 322	W322 Revised the "Emergency Medical Treatment – No Nurse on Site" policy which addresses staff accountabilities; all of which should be done 'immediately" including notification of the nurse. Staff trained on revised policy. Review of the importance of timely medical appointments and follow up with recommendations with nursing staff. (meeting/training scheduled for 9/27/07)	9/24/07 9/27/07

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W 322	Continued From page 33 the knees and sat down on the floor. The client was then assisted by two direct care staff to stand and was escorted to the bathroom, where she sat on the side of the tub while she was bathed. There was no evidence that the direct care staff or their supervisors contacted nursing/medical personnel. Further review of the investigative report revealed that the medication nurse was informed of the client's condition when she arrived to the facility to administer morning medications (time unknown). She assessed the client at 8:00 AM (2 1/2 hours after the incident). At approximately 9:00 AM (1 hour after the nurse's assessment) the facility's Registered Nurse (RN) was telephoned by the medication nurse and informed of the client's inability to stand, her swollen legs, and that she appeared to be in pain. Two RNs (supervisor and primary care nurse) arrived separately to the facility between 9:30 AM and 10:00 AM. The investigative report indicated that the RNs did not assess Client #3 or contact the Primary Care Physician (PCP) until 11:00 AM (5 1/2 hours) after the incident. At that time, the PCP instructed the RN to send the client to the ER for further evaluation. The client was evaluated at the hospital and diagnosed with a right hip fracture. 2. The facility failed to ensure an ENT assessment was provided for Client #3 as recommended. On August 15, 2007 at 5:43 PM Client #3 was observed to receive Deep Sea Spray, 2 sprays to each nostril. Interview with the nurse revealed the medication was prescribed as a moisturizer	W 322		

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W 322	Continued From page 34 for dry nasal mucosa. Record review revealed Client #3 was evaluated by the pulmonologist on October 3, 2006 and was diagnosed with purulent secretions of both nares and acute sinusitis. An ENT evaluation was recommended. Interview with the primary and supervisory RNs on August 17, 2007 at approximately 4:10 PM revealed the ENT assessment was scheduled for March 18, 2008, due to the specialist having no available appointments. There was no evidence Client #3 received a timely ENT assessment as recommended to correlate her sinus condition. 3. The facility failed to ensure a CT Scan of the sinuses was provided for Client #3 as recommended. Record review revealed Client #3 was evaluated by the pulmonologist on October 3, 2006 and was diagnosed with purulent secretions of both nares and acute sinusitis. The specialist noted that the client may require examination under anesthesia. A CT Scan of the sinuses was recommended and Avelox 400 mg x 10 days was prescribed for the infection. Record verification revealed the client went on appointments for the CT Scan on 11/15/06 and on 6/6/07 but was uncooperative to complete the procedure both times. Further record review revealed the CT Scan of the sinuses was completed on 7/05/07. Review of the consultation report revealed a defect involving anterior nasal septum and the turbinates were absent. The specialist indicated that the absence may be of a surgical nature, however this should be correlated by ENT, if no surgery had occurred. There was no evidence Client #3 received a timely CT Scan as recommended to correlate her	W 322	Sinus CT scan completed on 7/5/07. Scheduled to see pulmonologist on 9/25/07.	9/25/07

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W 322	Continued From page 35 sinus condition. 4. The facility failed to ensure that Client #3 had a pelvic sonogram as recommended by the gynecologist. Record verification on August 17, 2007 revealed Client #3 had a GYN appointment on October 17, 2006 for an annual pelvic examination. The examination was deferred due to the client's uncooperative behavior. The gynecologist however recommended a pelvic sonogram. At the time of the survey, there was no evidence the pelvic sonogram had been done. 5. The facility failed to ensure that Client #3 had a mammogram as recommended by the gynecologist. On August 16, 2007 at 9:00 AM, Client #3 was observed to be administered Ativan 2 mg by the primary Registered Nurse (RN). Interview with the nurse revealed the sedation was prescribed to improve Client #3's cooperation during her scheduled mammogram. At 9:45 AM the client was observed asleep in the chair. At 12:45 PM, interview with direct care staff revealed the staff called from the hospital to report that Client #3 was uncooperative for the procedure. At 4:02 PM, the client was observed returning from the incomplete appointment. Record verification on August 17, 2007 revealed Client #3 had a GYN appointment on October 17, 2006 for an annual pelvic examination. The examination was deferred due to the client's uncooperative behavior. The gynecologist however recommended a mammogram. At the time of the survey, there was no evidence the mammogram	W 322	Pelvic sonogram completed on 8/22/07.	8/22/07

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W 322	Continued From page 36 had been done. 6. The facility failed to ensure that Client #3 had a bone scan as recommended by the gynecologist. On August 16, 2007 at 9:00 AM, Client #3 was observed to be administered Ativan 2 mg by the primary Registered Nurse (RN). Interview with the nurse revealed the sedation was prescribed to improve Client #3's cooperation during her scheduled Dexa Scan. At 12:45 PM, interview with direct care staff revealed the staff called from the hospital to report that Client #3 was uncooperative for the procedure. Record verification on August 17, 2007 revealed Client #3 had a GYN appointment on October 17, 2006 for an annual pelvic examination. The examination was deferred due to the client's uncooperative behavior. The gynecologist however recommended a bone scan. At the time of the survey, there was no evidence the bone scan had been done.	W 322	Bone scan attempted 8/16/07, 8/30/07 and 9/19/07. The nurse will speak with the physician to determine feasibility of increasing amount of sedation medication. ENT appointment scheduled for March 2008 (unable to get earlier appointment due to few providers. Receptionist states that there are only a few slots for clients from group homes). Nurse made several attempts – called again on 9/24/07 to see if appointment could be moved to an earlier date.	9/24/07 9/24/07
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their assessed needs for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. [Cross Reference W322]. Interview with the	W 331		

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W 331	Continued From page 37 nursing staff and review of both the nursing notes and the investigative report, failed to provide evidence that Client #3's primary care physician was promptly notified, after a change in the client's health status was identified by the medication nurse (LPN) and/or the RNs. 2. [Cross Reference W322] According to the facility's investigative report dated March 14, 2007, when the medication nurse arrived to the facility to administer clients' medication, she was informed at that time of Client #3's condition. Interview with the nursing staff (Primary RN and Supervisory RN) and review of the incident report dated 2/28/07 revealed that the client was assessed to be in pain at 8:00 AM. Review of the Medication Administration Records revealed that Client #3 received Tylenol 650 mg by mouth for pain on February 28, 2007 at 7 AM from the medication nurse, prior to the nursing assessment.	W 331	W331 Revised the "Emergency Medical Treatment – No Nurse on Site" policy which addresses staff accountabilities; all of which should be done "immediately" including notification of the physician. Staff trained on revised policy. Educate nursing staff on writing progress notes – specifically, distinguishing how to indicate time of events in the notes vs. the time of the note, which will aid in clarifying the sequence of events. (meeting/training scheduled for 9/27/07)	9/24/07 9/27/07
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure that comprehensive dental services were provided timely, for one of three clients in the sample. (Client #3) The finding includes:	W 356	W356 Client went to the dentist on 6/11/07 for examination and scaling (as previously ordered). Scaling was not done at this time (per consult) by the dentist who made the recommendation. Still awaiting pre-authorization (since fall 06). Nurse contacted dental office on 9/24/07 to remind them to obtain pre-authorization.	9/24/07

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W 356	Continued From page 38 The facility failed to ensure that Client #3 received timely dental maintenance and treatment services. On August 15, 2007 at 4:21 PM, Client #3 was observed chewing canned fruit cocktail continuously in the front of her mouth. Interview with staff sitting beside the client while she ate indicated the client did not have a problem chewing. The review of a dental consultation dated September 13, 2006 revealed scaling of the clients teeth was recommended and that authorization would be awaited. During the next appointment on June 11, 20007, the same dentist diagnosed "Mobile tooth #11 and gross decay of tooth #3". The dentist indicated that an appointment would be scheduled to treat the client once the authorization had been obtained. Interview with the primary RN on August 17, 2007 at approximately 4:00 PM revealed the client received an appointment for the scaling of her teeth on 6/11/07, however the dentist did not perform the scaling the client's teeth on that date. Further review June 11, 2007 consultation report revealed no further mentioning of dental scaling that was previously recommended by the dentist.	W 356		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts.	W 440	W440 All staff has been trained in appropriate and timely fire drills.	9/24/07

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W 440	Continued From page 39 The findings include: Interview with the Program Manager on August 16, 2007 at 11:37 AM revealed the direct care staff were assigned to the 3:00 PM - 11:00 PM or 11:00 PM - 7:00 AM shift. Further interview with the program manager indicated usually the residents were not in the facility during the hours of day program operation. Review of the fire drill records from September 2006 through July 2007 revealed none were documented during the following periods: a) 3:00 PM - 11:00 PM shift - September through December 2006 b) Weekend day shift: none from September 2006 through July 2007 c) Weekend overnight shift: None between since September 30, 2006 and March 4, 2007	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an active program for prevention of potential communicable disease for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include: 1. On August 16, 2007 at 8:00 AM, a direct care staff was observed carrying a basket containing hair grooming supplies, which also included hair	W 455	W455 All staff has been trained in Infection control. New hygiene kits, brushes,combs, etc. have been purchased and all items have been individually labeled.	9/24/07

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W 455	Continued From page 40 brushes and combs. The staff was observed grooming the hair of Clients #1, #3, #4, and #5 in the living room prior to their boarding the bus for their day programs. The staff was not observed to wash her hands after grooming each client's hair. Further observation and interview with the staff revealed the brushes and combs had no identification. Subsequent observation at 8:50 AM on the same morning and interview with the staff revealed several brushes and combs, in addition to grooming supplies stored together the basket on the closet shelf in Client #1's bedroom. The staff indicated that they were stored in this manner to prevent Client #5's from rummaging. There was no evidence the facility exercised infection control procedures during hair grooming. 2. On August 16, 2007 at 8:57 AM Client #3 observed to getting up from the upholstered chair. A large circular wet area was observed in the seat of the client's pants and also on the chair. The client's wet pants were discovered by staff and changed at 9:25 AM. The seat of the chair was not observed to be cleaned during the survey.	W 455		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460		
W 488	This STANDARD is not met as evidenced by: 483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental	W 488	W488 All staff has been trained in infection control. All staff have been trained on providing consumers opportunities for active treatment during the meal time process to include family style dining and serving themselves if capable.	9/24/07

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W 488	Continued From page 41 level. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that two of five clients residing in the facility ate in a manner consistent with their developmental level. (Clients #3 and #4) The findings include: 1. On August 16, 2007 at 7:20 AM during breakfast and again on August 16, 2007 at 5:30 PM during dinner, Clients # 1 and #4 were observed with a large, long bib tied around their necks as they ate their meals. The ends of the bib were used as a placement, as they extended from the client's neck to underneath the plates on the table. At 7:22 AM on August 16, 2007, Client #1's plate was observed to slide on the bib as she attempted to scoop food from it using her right hand. Interview with staff indicated the bib is used to prevent the client from soiling their clothing while feeding themselves. The client was observed to have a piece of bacon on her plate approximately 3 inches long which she was not able to spoon into her mouth. Record review on August 17, 2007 at 1:40 PM revealed Client #1 is unable to use her left hand. On August 16, 2007 at 7:35 AM Client #4 was observed to remove the bib from her neck after finishing her meal. The bib remained on the table underneath the plate and the crumbs fell onto the client's lap. There was no evidence the clients were provided with an appropriate place mat for use during their meals.	W 488		

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W 488	Continued From page 42 2. The facility failed to ensure clients were provided the opportunity to participate in family style dining. a. The clients were observed during dinner on August 15 and 16, 2007 and during breakfast on August 16, 2007. Clients #2 and #5 were observed participating in setting the table by putting placements and silverware on the table. Staff were observed to be served onto the plates in the kitchen by the direct care staff, then brought to the dining room table to be eaten by the clients. Interview with staff revealed that some of the client's may be able to put food onto their plates with assistance. There was no evidence the clients were provided an opportunity to participate in family style dining.	W 488		

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I 000	INITIAL COMMENTS A recertification/licensure surveys was conducted from August 15, 2007 through August 17, 2007. A random sampling of three residents was selected from a residential population of six females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews and the review of resident and administrative records including incident reports.	I 000		
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: The GHMRP failed to ensure that the dining room was equipped with chairs designed to meet the developmental needs of Residents #1, #3 and #4. The finding includes: 1. On August 16, 2007 at 8:57 AM Resident #3 was observed to get up from a fabric upholstered dining chair which was placed beside the front door. A large circular wet area was observed in the seat of the client's pants and also on the seat of the chair. (Note: There was no evidence the upholstery was cleaned during the survey.) 2. On August 16, 2007 at 7:20 AM during breakfast and again on August 16, 2007 at 5:30 PM during dinner, Residents # 1 and #4 were observed with a large, long bib tied around their	I 052	I 052 (1) All chairs will be cleaned by staff using the appropriate cleaning solution. All staff have been trained in infection control procedures. (2) Placemats will be purchased in placed in the home.	10/15/07 9/30/07

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I 052	Continued From page 1 necks as they ate their meals. The ends of the bib were used as a place mat, as they extended from the resident's neck to underneath the plates on the table. There was no evidence the residents were provided with an appropriate place mat for use during their meals.	I 052		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The facility failed to maintained the environment as evidenced by the concerns identified in this section of the report. The findings include: The surveyor conducted environmental observations during the survey and during the environmental rounds on August 17, 2007 beginning at 4:00 PM. The surveyor was accompanied through the GHMRP by the Program Manager. 1. A long crack was observed across the width of the top step at the front of the GHMRP. 2. Several holes were observed in the interior (front) basement wall. Interview with the program manager revealed water entered the wall from the exterior of the facility approximately one week prior to the survey due to a water hose being left on.	I 090	I090 (1) Front concrete steps will be repaired. (2) Interior basement wall will be repaired.	11/1/07 11/1/07

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I 090	Continued From page 2 3. On 8/15/07 at 5:14 PM, a beeping noise was heard coming from a red box installed on the basement wall . Several minutes later the noise had stopped. The same noise was heard intermittently throughout the day on 8/17/07. Interview with the Program Manager on August 17, 2007 at 4:50 PM revealed the beeping noise was came from the alarm system. Resetting the system temporarily stopped the beeping noise, however it continued to return. The program manager indicated that efforts to correct the problem had been futile. 4. The splash block below the downspout at the left rear corner of the GHMRP was observed to be broken into several pieces. 5. Two of the exterior window well covers were broken. 6. Several cracked tiles were observed on the dining room floor and the floor of the hallway near the rear exit. Several heavily stained tiles were also observed on the dining room floor. 7. The bottom of the cabinet underneath the kitchen sink was detached from the sides of the cabinet causing the floor to be visible. 8. The bottoms of the kitchen cabinet shelves felt sticky when touched. 9. No lid was available for the trash can in the kitchen. 10. Low lighting was observed in the dining room. One of four light bulb in chandelier was observed to be burned out. Maintenance was notified. 11. Part of the floor covering had been removed	I 090	(3) Alarm system will be repaired. (4) A splash block will be purchased. (5) The broken window well covers will be replaced. (6) The dining room and hallway floor tiles will be replaced. (7) The kitchen sink cabinet will be repaired. (8) The kitchen cabinets will be thoroughly cleaned. (9) A new kitchen trash can with a lid will be purchased. (10) The chandelier bulb will be replaced. (11) The rubber floor covering on the steps will be replaced. (12) The hallway door will be repaired/and or replaced.	11/1/07 10/15/07 10/15/07 11/1/07 11/1/07 11/1/07 9/30/07 9/27/07 11/1/07 11/1/07

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I 090	Continued From page 3 from the steps leading to the basement and the steps had not been resurfaced to render them easily cleanable. 12. The door of the bathroom located off the hallway would not open completely. Further observation of the door revealed it dragged against the floor near the bathroom storage cabinet.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: The finding includes: Based on interview and record review, the GHMRP failed to conduct simulated fire drills at least four (4) times a year for each shift. The findings include: Interview with the Program Manager on August 16, 2007 at 11:37 AM revealed the direct care staff were assigned to the 3:00 PM - 11:00 PM or 11:00 PM - 7:00 AM shift. Further interview with the program manager indicated usually the residents were not in the facility during the hours of day program operation. Review of the fire drill records from September 2006 through July 2007 revealed none were documented during the following periods: a) 3:00 PM - 11:00 PM shift - September through December 2006 b) Weekend day shift: none from September	I 135	I 135 Staff have been trained in the appropriate and timely implementation of fire drills.	9/24/07

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I 135	Continued From page 4 2006 through July 2007 c) Weekend overnight shift: None between since September 30, 2006 and March 4, 2007	I 135		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain complete accounting of funds disbursed for Residents #1, #2, ad #3. The findings include: Interview with the program manager on August 16, 2007 at 11:43 AM revealed the group home manager maintained the receipts of the Residents' expenditures and submitted them to the administrative office for review and filing in the residents financial records. Further interview with the program manager revealed the group home manager had not been on duty since August 14, 2007. Record review on August 16, 2007 beginning at 11:52 AM revealed the following information concerning the finances of the residents: a) The review of the bank statements for May 2007 revealed on May 14, 2007 Residents #1, #2, and #3, each had a withdrawal of $250.00 from their accounts. The review of the requests for the funds indicated the money was be used for clothing and personal items. The review of available financial records revealed no receipts were available for the $250.00 withdrawals. Interview with the program manager on August 16, 2007 at 12:36 PM indicated that follow-up	I 189	I 189 The house manager responsible for the missing receipts left NCC unexpectedly and NCC was unable to recover the receipts. QMRP and staff will be trained on appropriate receipt submission.	9/24/07

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I 189	Continued From page 5 was needed to determine if the receipts had been submitted to the financial office. b) The review of Resident #1's bank statements from September 2006 through July 2007 revealed the bank statements reflected a balance of $100.00 less than the facility's ledger balances. Further review of the facility's monthly ledgers revealed the discrepancy was initially discovered by the facility in September 2006. A note on the December 2006 bank statement indicated "There is a $100.00 difference in the bank and book ledger. We are still waiting to follow-up with the bank on this issue." At the time of the survey, there was no evidence a thorough investigation had been conducted to determine the origin of the discrepancy between the resident's bank and ledger balances.. c) Interview with the program manager on August 16, 2007 at 11:55 AM revealed the residents went on a summer vacation in another state during July 2007. The review of the July 2007 bank statements revealed a withdrawal of $530.00 on July 23, 2007 for Residents #1, #2, and #3. Interview with the program manager revealed the home manager maintained the receipts and they were not available for review during the survey.	I 189		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on interview and record review, the	I 202		

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N C C	617 DAHLIA STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 202	Continued From page 6 GHMRP failed to ensure that written job descriptions for the direct care staff were available for review The finding includes: Interview and record review with the Quality Assurance Coordinator on August 17, 2007 revealed the job descriptions were not available for S1, S2, S3, S4, S5 and S6.	I 202	I 202 All staff will review and sign a written job description.	10/1/07
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that current training on cardiopulmonary resuscitation (CPR) was maintained for each employee. The finding includes: The review of training record provided to the surveyor for review on August 16 and August 17, 2007 revealed that two of the six employees working with the residents lacked evidence of a current CPR certification. The identified staff were Staff #'s S2 and S5. Program Manager acknowledged during interview that the CPR certification for the identified staff had either expired or not been completed for the two staff.	I 226	I 226 All staff will be trained in CPR/First Aid training.	10/31/07
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry.	I 291		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 291	Continued From page 7 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the record of each resident was kept current with date and signature of all persons making an entry in the records. (Residents #1, #2 and #3) The findings include: [See Federal Deficiency Report - Citation W114]	I 291	I 291 An access log will be added to all staff consumer record for signature by staff accessing the record.	10/1/07
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided timely for two of three residents in the survey. (Residents #1 and #3) The findings include: The GHMRP failed to ensure health services were provided in accordance with the needs of Residents #1 and #3. [See Federal Deficiency Report - Citations W322, W331 and W212]	I 401	I 401 Cross-reference W322, W331, and W212	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with	I 422		

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I 422	Continued From page 8 the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure Residents #1, #2, and #3 were provided habilitation, training and assistance with their Individual Habilitation Plan (IHP). [See Federal Deficiency Report - Citation W227, W249 and W252]	I 422	I 422 Cross-reference W227, W249, W252	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The finding includes: 1. The GHMRP failed to ensure the rights of Residents #1, #2, and #3 to an accurate accounting of personal funds. [See Federal Deficiency Report - Citation W140] 2. The facility failed to develop and implement policies and procedures on health and safety for Resident #3. [See Federal Deficiency Report - Citations W149, W154 and W156] 3. The facility failed to ensure the rights of Clients #1, #2, and #3 to habilitation and training.	I 500	I500 (1) Cross-reference W140 (2) Cross-reference W149, W154, W156 (3) Cross-reference W227, W249, W252 (4) Cross- reference W322, W331, W356, and W212	

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R 000	INITIAL COMMENTS A recertification/licensure surveys was conducted from August 15, 2007 through August 17, 2007. A random sampling of three residents was selected from a residential population of six females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews and the review of resident and administrative records including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for two of six staff. The finding includes: Review of the review of personnel files on August 3, 2007 at 9:20 AM revealed the GHMRP failed to evidence criminal background checks for the previous seven years in all jurisdiction where two staff had worked or resided. The review of criminal background checks provided revealed none were provided for Staff #3 and #5.	R 125	R 125 Criminal background checks will be done on all staff.	10/31/07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X5) DATE

Program Manager 9/04/07

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